Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966123	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE CARE FAMILY HOME, CORP	4221 WEST 5 LANE HIALEAH, FL 33012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (#2022018967) was conducted at Grace Care Family Home, Corp. on [redacted] through [redacted]. The provider had deficiencies identified at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision for one of five sampled residents (Resident #1) who suffered a on sustaining a on her and another on sustaining a right , Findings included: A review of Resident #1's health assessment Completed on stated that the resident had been diagnosed with:	A 025		

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A 025	Continued From page 2 , Right . Stable, Skin . She had general , was able to transfer with maximal assistance. Resident was receiving hospice services and was oriented to names, forgetful. She was on and , precautions. The resident required assistance with ambulation, eating and transferring and total assistance with bathing, , grooming and toileting. She had no , and required medication administration. A review of Resident #1's hospice's progress notes revealed that she had been admitted to Hospital status post and , ; the family refused surgery due to the resident's age. A review of Resident # 1's progress notes reveled that Resident # 1 had suffered a on and suffered a on the left side of her forehead. On resident tried to stand up from seat and lost balance and rotated and hit her against the seat feeling on right ; her son and her doctor were notified, and she was taken to Hospital. An entry from revealed the the resident was ; not sleeping at night walking around. Discharge from rehab where she was admitted from to stated that she had of unspecified part of of right , subsequent encounter for closed without routine healing. She was at rehab for , care. On at 12:01 PM Staff A stated, "She was superfast, Staff D had just been in front of her and went to the kitchen and the resident tried to get out of the recliner and made a sudden turn and hit her with the armrest."	A 025		

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A 025	Continued From page 3 On at 12:32 PM Staff D stated, "I was in the kitchen at that moment preparing lunch, and since we were always paying attention to her, when I looked at her, she was standing up and I tried to grab her quick and she hit the with the recliner, but she did not , she never got to the floor. I called Staff B who was on the backyard to help me with her." Class III	A 025		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health	A 162		

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A 162	Continued From page 4 care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for Optional State	A 162		

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A 162	Continued From page 5 Supplementation (. . .), CF-ES 1006, ... , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the . , , ... of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's . . . . . , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.	A 162		

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A 162	Continued From page 6 (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have an accurate health assessment for one out out of five sampled residents (Resident # 1). Findings included: On at 8:07 AM observed Resident # 1 in bed with intended to provide relief from , and full side rails up, unable to answer to respond when spoken to. On at 11:04 AM the Registered Nurse from hospice stated that at this time the resident had an DTI (, ,) on the left heel and that they had just written an order for care three times per week. On at 11:40 AM the Administrator stated, "She came from the hospital last night and now she requires total assistance. The hospice's doctor needs to do a new health assessment."	A 162		

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A 162	Continued From page 7 On [redacted] at 12:40 PM the Administrator stated, "when she came from rehab, she was almost total, but we did not prepare a new health assessment. The [redacted] just developed now at the hospital." A review of Resident #1's health assessment completed on [redacted] stated that the resident had been diagnosed with: [redacted], Right [redacted] Stable, Skin [redacted]. She had general [redacted], was able to transfer with maximal assistance. The resident was receiving hospice services and was oriented to names, forgetful. She was on [redacted] and [redacted], [redacted] precautions. The resident required assistance with ambulation, eating and transferring and total assistance with bathing, [redacted], grooming and toileting. She had no [redacted] and required medication administration. Class III	A 162		